PLEASE DO NOT STAPLE IN THIS AREA					°FOHC/RHO °Interper	C riodic Scre	eeni	.ng			
PICA						SURANCE C			RM		PICA
MEDICARE M     (Medicare #) X (Medicare #)		HAMPUS consor's SSN	CHAMPV (VA File	HEALTH PLAN	FECA OTHE BLK LUNG (SSN) (ID)	90000000000000000000000000000000000000		3		(FOR I	PROGRAM IN ITE
2. PATIENT'S NAME (La	st Name, First Name	e, Middle Initia	al)	3. PATIENT'S BIRTH DAT MM DD 1984		4 INSURED'S NAME		ame, Fir	st Name	. Middle	e Initial)
5. PATIENT'S ADDRESS				06 11 1984		7. INSURED'S ADDR	RESS (No	o. Street	3		
13 Lucky Du	rck Lane				Child Other						
CITY			STATE NC	8. PATIENT STATUS Single Marrie	ed Other	CITY					STATE
Raleigh ZIP CODE	TELEPHO	NE (Include A		1		ZIP CODE		TEI	EPHON	NE (INC	LUDE AREA COL
27600 9. OTHER INSURED'S N	27600 ( 919 ) 555–1212 9. OTHER INSURED'S NAME (Last Name, First Name, Middle In			Employed Full-Tin Student	t Student	11. INSURED'S POLI	CY GRO	DUP OR	( FECA N	) IUMBEF	4
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b. OTHER INSURED'S D.		SEX		b. AUTO ACCIDENT?	PLACE (State)	b. EMPLOYER'S NAM	ME OR S	CHOOL			
c. EMPLOYER'S NAME O	M SCHOOL NAME	· .	F	c. OTHER ACCIDENT?	NO	c. INSURANCE PLAN	NAMF I	OR PRO	GRAM P	NAME	
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d. INSURANCE PLAN NA	ME OR PROGRAM	NAME		10d. RESERVED FOR LOC	d. IS THERE ANOTHE	NO NO				complete item 9 a-	
12. PATIENT'S OR AUTH	READ BACK OF F	ORM BEFOR	RE COMPLETING	G & SIGNING THIS FORM. release of any medical or other	er information necessary	13. INSURED'S OR All payment of medical	UTHORI	ZED PE	RSON'S	SIGNA	TURE I authorize
to process this claim. I below.	also request paymer	nt of governme	ent benefits eithe	r to myself or to the party who	accepts assignment	services described		s to the i	undersig	ineu prij	ysician or supplier
SIGNED				DATE		SIGNED					
SIGNED	ILLNESS (First	tent) OR	PR 15.	DATE IF PATIENT HAS HAD SAME GIVE FIRST DATE MM	OR SIMILAR ILLNESS.		UNABLE YY	то wo	RK IN C	URREN MM	NT OCCUPATION
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